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Syrjänen, Milla

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Attachment and sensitivity among parents with ADHD – A multiple-case study

Authors

Milla Syrjänen,[1] Airi Hautamäki,[2] Natalia Pleshkova,[3] and Sinikka Maliniemi[4]

[1]
Faculty of Educational Sciences, University of Helsinki, Finland.

[2] Swedish School of Social Science, University of Helsinki, Finland

[3] Division of Child and Parent Mental Health and Early Intervention, St.Petersburg State University, Russian Federation

[4] Private practice in psychotherapy, Helsinki, Finland

Abstract

This study aimed to explore the self-protective strategies of six parents with ADHD and the sensitivity they displayed in dyadic interaction with their under 3-years-old children. The parents were interviewed using the Adult Attachment Interview. Parental sensitivity was assessed using the CARE-Index. The study showed a variation of the parents' self-protective strategies and sensitivity. The more complex the parent's self-protective strategy was, the less sensitive was the interaction. Some parents' need for self-protection compromised their ability to protect their child and decreased their sensitivity. All parents displayed indications of unresolved traumas, which also impaired their sensitivity to the signals of their child and ability to engage in mutual regulation of arousal and emotion with their child. Attachment-oriented family psychological assessment, including assessments of the self-protective strategies of each family member would make possible to design a treatment adapted to the unique family needs, also in order to alleviate early risk.

Keywords

ADHD, attachment, self-protective strategy, sensitivity

Introduction

Attention deficit hyperactivity disorder (ADHD) is a common psychiatric condition, characterized by symptoms of inattention, hyperactivity and impulsivity (see American Psychiatric Association 2013) and argued to develop as the result of the interplay between genetic and environmental factors (Thapar and Cooper 2016). In attachment theory, ADHD has been conceptualized as a disorder of self-regulation rooted in troubled early caregiver-child interactions (Clarke et al. 2002), and connected with insecure and disorganized attachment of the child (see Storebø, Rasmussen, and Simonsen 2016). In addition, ADHD is associated with troubled parenting. The focus of the previous studies has been in parenting children with ADHD (see Deault 2010). Some studies have shown difficulties in parenting, if the parent has ADHD (Johnston et al. 2012) or if both the parent and the child have ADHD (Chronis-Tuscano et al. 2008; Ellis and Nigg 2009; Murray and Johnston 2006). Early parental sensitivity of adults with ADHD has been examined in only one previous study (Semple et al. 2010). In this study maternal ADHD symptoms were associated with troubled maternal caregiving behaviors during infancy. Although Cavallina et al. (2015) analyze attachment in the context with reflective functioning, there are few previous studies connecting parental attachment strategies with sensitivity. Thus, in the present study we explored the self-protective strategies and sensitivity of parents with ADHD.

Parental sensitivity, defined as a multi-step process including the ability to accurately perceive and interpret infant signals as well as promptly and appropriately reacting to them (Ainsworth, Bell, and Stayton 1974) is essential during the first three years, when the child is navigating through successive stage-salient tasks related to self-regulation, e.g. from establishing physiological regulation, taking turns, establishing joint attention and forming attachment relationships. Sensitivity is the precondition for two parental functions, protecting and comforting the immature child (Crittenden 2016). Protection refers to keeping the child safe physically and emotionally so that the child can fully develop his physical and psychological resources. Comfort means that the child can use his parents as a secure base from which he safely can explore the world as well as secure haven to return to, when he needs comfort. Exploration includes that child is assisted in learning to use his own mind to create self-protective meaning from his experiences – a condition for that achieving genuine independence by adulthood (Landini, Crittenden, and Landi 2016). Attachment theory analyzes differences in these parental functions (Bowlby 1980; Crittenden 2016) and stresses that parenting is based on the parent's dispositional representations of attachment as assessed by the Adult Attachment Interview, AAI (George, Kaplan, and Main 1985). In particular, the DMM AAI (Crittenden and Landini 2011) can identify parents whose children may be at risk through inadequate protection from danger, insufficient comfort and lack of clarity of communication.

The present study was conducted using The Dynamic Maturational Model of attachment and adaptation, DMM (Crittenden 2006) that 'construes human behavior in terms of organized self-protective strategies that function to maximize protection under threatening conditions' (Farnfield et al. 2010, 314). The array of DMM protective strategies are grouped as Types A, B and C, originally identified by Ainsworth (Ainsworth et al. 1978), with many sub-strategies, as described by the DMM (Crittenden 2016; see Figure 1). Crittenden offers a model how the parents' protective strategies, based on the information-processing of attachment-relevant information guide their parenting. Parental protective behaviors are clustered based on the extent of transformation of information of their child. The gradient of distortion in the parenting clusters (Crittenden 2016) is based on Ainsworth's definition of sensitivity: to perceive the signal, interpret it correctly and promptly respond to it in an

adequate way. In the present study, following Landini, Crittenden, and Landi (2016), the classic Ainsworth strategies in the normative range (A1-2, C1-2) were considered low risk. The higher A+ and C+ strategies elaborated by the DMM ranged from moderate risk (A3-6, C3-6) to high risk (A7–8, C7-8, AC). The risk was defined in terms of the gradient of transformation of attachment-relevant information (Crittenden 2016). In regard to parenting, strategies numbered `3–4´ indicate that parents at times may act self-protectively, transforming information in a way that confuses their own needs with those of their child, `5–6´ indicates transformations that parents at times act self-protectively rather than child-protectively, and `7-8´ indicate distortions of information ranging to delusionally construing the child as a threat to the parent (Landini, Crittenden, and Landi 2016; Crittenden 2016) for a gradient of transformation of information). Instead of offering adequate protection and comfort and instead of helping the child to make meaning of his experiences, the distressed parent may feel urged act self-protectively (Crittenden 2016).

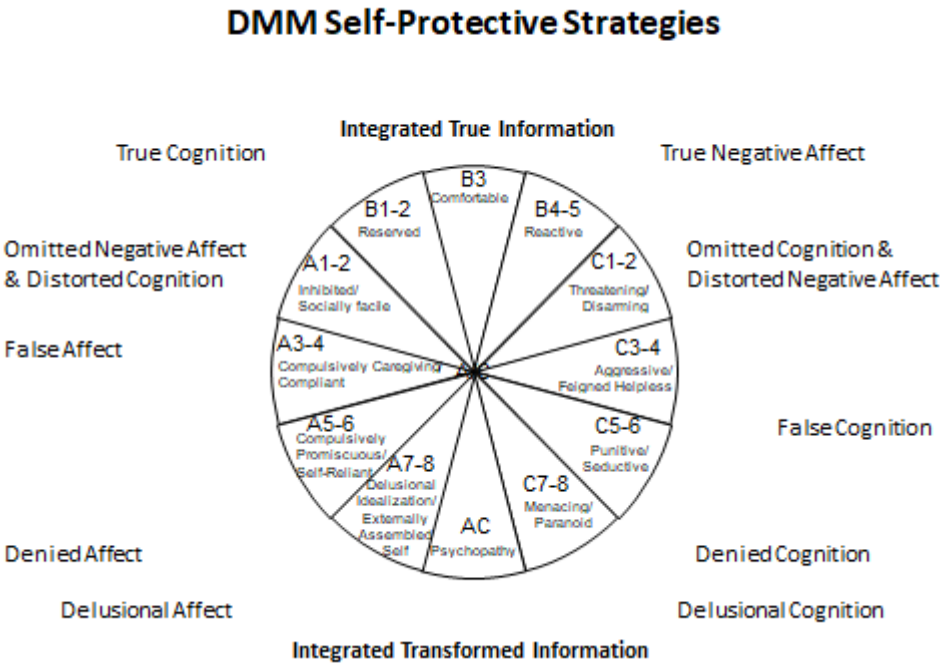

Figure 1. DMM Self-Protective Strategies (© Patricia M. Crittenden, used with permission)

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The current study

We aimed to explore the self-protective strategies of parents with ADHD and the sensitivity they displayed in dyadic interaction with their child. The study utilized the DMM attachment framework for the analysis and synthesis of data (Farnfield et al. 2010). We assumed that the degree of risk (Landini, Crittenden, and Landi 2016) associated with the self-protective strategy of the parent as indicated by Crittenden's (2016) gradient of transformation of information would yield different outcomes in terms of parental sensitivity. We also assumed that if the parents with ADHD would use more extreme self-protective strategies connected to transformed patterns of information processing, then their parenting would be more self-protective than child-protective, and less sensitive.

The multiple-case study design was fit for the exploratory purpose of this study. Case-study research has played an important role in developing new ideas in clinical practice (Dallos and Smart 2010; Robson 1993). The purpose of the present study was descriptive, not hypothesis-testing (Glaser and Strauss 1967).

Method

Participants

The study was approved by the Medical Ethical Committee of the University Hospital in question. The respondents gave written informed consent. Six parents (five mothers, one father, mean age = 32 years; range = 23.0–39.3) and their under 3 years old children were recruited from a University Central Hospital, Department of Psychiatry, Clinic for Neuropsychiatry. All the clients of this clinic, who fulfilled the inclusion and exclusion criteria were invited to participate in the study between January 2013 and November 2015. However, the respondents were hard to find, because individuals with ADHD often have other psychiatric diagnosis. For the inclusion in the study, parents: (1) were between the ages of 22 and 45; (2) had received the ADHD diagnosis from a University Central Hospital, Department of Psychiatry, Clinic for Neuropsychiatry; (3) were no longer living at home with family of origin; (4) spoke Finnish as the first language; (5) had received at least six Apgar points at the time of birth in order to exclude severe learning difficulties; (6) had a 0–36 months old child, who was able to participate in the study as well. For the exclusion, parents: (1) had a comorbid DSM-IV diagnosis and ongoing regular use of psychotropic medicines, except for the ADHD-medication, at the time of the study; (2) had participated in any form of psychotherapy before or at the time of the study. The parents had received the ADHD diagnosis and had started ADHD medication in adulthood, but during the diagnostic process, it was verified that they had shown ADHD symptoms already when they were children. With the exception of one parent, all had the ongoing ADHD-medication at the time of the study. All parents lived with their children. With the exception of one single parent mother, all parents cohabited or were married with their partners at the time of the study. The parents are identified as P1-P6 and the children with pseudonyms.

Assessments

The DMM AAI

The parents were interviewed using a semi-structured, standardized and validated modified AAI-interview (Crittenden and Landini 2011), elaborated from the Adult Attachment Interview, AAI (George, Kaplan, and Main 1985). The interviews were audiotaped and transcribed verbatim. In the DMM AAI, questions are posed about the adults' childhood

relationships with their parents, in particular, the protective and comforting function of the parents. It offers information on the access to and specific use of memory systems and discourse strategies employed in the speaker's construction of his attachment experiences (Crittenden and Landini 2011). The DMM AAI takes a systemic approach to children's development and offers both a wider and more subtle description of the attachment strategies than the more familiar Main and Goldwyn (1984[1994]) system. The DMM AAI is particularly suited to differentiate among endangered individuals, who have developed complex self-protective strategies outside the normative ABC range, originally described by Ainsworth et al. (1978). The normative A1-2, B1-5 and C1-2 strategies indicate little or no transformations of information and low risk in regard to parenting compared to the DMM strategies in the medium range (A3-6, C3-6) and in the high range (A7-8, C7-8, AC and A/C) (Landini, Crittenden, and Landi 2016; see Figure 1). In the present study, A3-8 strategies are termed as A+ and C3-8 strategies as C+. The risk was defined in terms of the gradient of transformation of attachment-relevant information (Crittenden 2016).

The AAI transcripts were coded and classified on the basis of their overall fit to the attachment categories elaborated by the DMM AAI (Crittenden and Landini 2011) by two coders, trained by P.M. Crittenden, of which one had research-level reliability. The interrater agreement on the AAI major category was 100% for the Type A+ and Type A+C+ transcripts including disorientation, which is a modifier rendering behavior nonstrategic, neither self-protective nor eliciting comfort (Crittenden and Landini 2011). The markers of a particular strategy are present, but the speaker cannot use the strategy to protect himself. The speaker shows high arousal and presents incompatible versions of past and present sliding from one perspective to the next without being aware of it. She is not able to explore and resolve discrepancies between her own and conflicting parental representations and to choose the representations that serve her own interests (Crittenden and Landini 2011). Reorganization is a modifier that reflects an emergent process of change from one strategy to another (Crittenden and Landini 2011). The two coders agreed on partial reorganization in two transcripts. In two transcripts, the coders agreed on the C component, but there was dissent regarding an additional A component. By a careful analysis of the functions of the markers in different memory systems and the level of arousal of the speaker (Crittenden and Landini 2011), the coders agreed that the A component was not substantiated.

Main and Goldwyn (1984[1994]) identify evidence of preoccupying lack of resolution of trauma or loss. The DMM AAI identifies also other forms of psychological responses to unresolved trauma or loss (Crittenden and Landini 2011). Markers of a trauma in the discourse are that a trauma momentarily interrupts the coherent narrative (that is, incoherent speech around danger in the AAI discourse) indicating a break in the strategic self-protective functioning. Actually, an individual's type of trauma may display a reversal to his usual strategy, i.e. dismissed trauma in a Type C+, or preoccupied loss in a Type A+ strategy (Crittenden and Landini 2011). The two coders agreed on traumas and losses. There were some discussions in regard denied vs dismissed trauma regarding early emotional neglect.

The CARE-Index

The sensitivity of the parents was assessed using the CARE-Index, which is an observational assessment procedure for categorizing parental and child patterns of interaction based on 3–-5 minutes of videotaped semi-structured play interactions. The infant method (Crittenden 2010) can be used with children from birth to 15 months and the toddler method (Crittenden 2005), including a frustration task, with children aged between 16 and 72 months. The focus is on relationships, not individuals, i.e. the parents' and children's interactive behaviours are assessed as dyadic, each in the context of the other (Crittenden 2010; Hautamäki 2014). The

assessment is less based on frequency counts of specific behaviours than on categorical judgements of the function of behaviours in the interactive flow. The adult codes aim to assess adult sensitivity to child`s signals under low stress conditions through three aspects: sensitivity, control, and unresponsiveness. The Infant and Toddler CARE-Index, provide a 14-point Dyadic Synchrony Scale, where values of 11–14 are classified as 'sensitive' and 7–10 as 'adequate' (adequate range). Adequate sensitivity is defined as 'adequate play that is characterized by noticeable periods of dys-synchrony (either controlling or unresponsive)' (Crittenden 2010, 21). Values of 5–6 are classified as 'inept' (intervention range), defined as 'Clear, unresolved problems; limited playfulness, but no evidence of hostility or lack of empathy' (Crittenden 2010, 21). Values of 0–4 represent 'at risk' (high-risk range). The range of 3–4 is defined as 'Clear lack of empathy, nevertheless, some feeble (insufficient or unsuccessful) attempt is made to respond to infant; lack of playful quality' and the range of 0–2 as 'Total failure to perceive or attempt to sooth the infant's distressed state; no play' (Crittenden 2010, 21). The videotapes were coded by two coders. One of the coders had research-level reliability in the Infant CARE-Index and the Toddler CARE-Index, and was blind to the cases. The coders agreed regarding the level of sensitivity and the type of insensitivity displayed. P.M. Crittenden classified four of the interactions. Her evaluations matched that of the coders.

Results

Parents were sorted by degrees of risk associated with their self-protective strategies as indicated by Crittenden's (2016) gradient of transformation of information to low-, moderate-, and high-risk groups (see Landini, Crittenden, and Landi 2016). The case-ordered meta-matrix (Robson 1993) consisted of three subgroups of parents for which different outcomes in terms of sensitivity were explored (see Table 1–3).

Low-risk group

Two parents displayed emergent, but only partial reorganization in regard to attachment, IO(R) (Crittenden 2015) and an adequate sensitivity with their child (see Table 1). IO means Insecure Other, that is, the dysfluencies of speech and distortions of thought do not fully fit the DMM self-protective strategies (Crittenden and Landini 2011).

P2 and his son Nils

P2, Nils's father dismissed early neglect occurring in his big childhood family with two hardworking parents, displacing his need for comfort to his little sister. He still partly idealized his mother, but he had started to repair his struggling relationship with his father. He realistically described how he, as a child and adolescent had been drawn into the schismatic spousal relationship and the triangulated family situation. He stated that he currently had good relationships to his parents, who both regretted that they worked so much, when their children were young. Reparation appeared to have started in P2's newly established dialogue with his parents. However, in order to work, this dialogue should also touch on how the early emotional neglect negatively impacted his feelings of worthlessness and lack of self-esteem. Sad feelings lurking beneath the presentation of the currently socially successful façade are still connected to dismissed early emotional neglect. Although P2 is able to describe both early emotional neglect and emotional abuse, he is not yet fully aware of its impact on his development. His feelings of worthlessness are also connected to earlier emotional abuse by his father, who had told him as he was younger that he was 'good for nothing'. Emotional abuse is associated with negative mental health outcomes, because it indexes issues that are

common to all forms of maltreatment. By demeaning the child, parents may instill in the child a belief that he is un-loved and worthless (Cecil et al. 2017). P2's greatest fear is to be excluded, to be rejected and un-loved, if failing expectations. For this reason, P2 feels grateful for being included in his family of origin again, acknowledged and accepted by his father. He is disposed to perform, currently studying to become a highly trained professional.

In Toddler CARE-Index, P2 showed adequate sensitivity. He was playing in a relaxed way smiling disarmingly to Nils, trying to soften the frustration and negotiate with his son. P2 adapted nicely to Nils, also in the role of a playmate.

P4 and her daughter Annina

P4, Annina's mother had idealized her childhood father, and currently had conflicted feelings regarding him. She was still preoccupied by and sad about the domestic violence perpetrated by her father on her mother and the triangulated family situation into which she was drawn. She often returned to the theme in the AAI and expressed a strong wish to reverse it with her own children. P4 had had a caregiving and a go-between role regarding her mother. However, she was able to articulate realistically her complex position in the triangulated family. In the wake of father's harsh physical abuse of her mother, she had gradually de-idealized him and distanced herself from him. She has learnt to understand that her mother was very stressed as she was a child, resulting in a more nuanced picture of her relationships to her parents – connected to sadness, because she accepted that she cannot any longer help them by going-between – they are too self-destructive and destructive to each other. Genuine sadness appeared in the AAI about events that had happened and still happened in her family of origin. Currently, she is affectively working through her cognitive, semantically stated insights. This is accompanied by sad feelings, because she realizes that she cannot change her parents' destructive relationship with each other. P4 is, however, able to draw the self-relevant and self-protective conclusions. She states that she has made it; she has succeeded in creating a safe family life with her husband for her own children. She is proud that she has been able to combat her greatest fear – to repeat the marital tragedy of her parents, the discordant and triangulated family system accompanied by severe domestic violence and abuse.

In the Toddler CARE-Index, P4 looked sad displaying a low-key communication (sitting relatively motionless with a rather still face). Mostly she left the initiation of activities to her daughter and Annina liked to be in control. Still, because P4 was able to think about and symbolize her abusive childhood experiences and get in touch with the fear, helplessness and anger connected to her adverse childhood experiences, she was able to perceive and keep her daughter's needs in her mind and display sufficient psychological availability to Annina (Berthelot et al. 2015). When introducing the frustration task, P4's face was vibrant. She displayed her psychological availability by following up and responding to Annina's initiations and responses. Instead of dismissing traumas by manic defenses and false positive affect, P4's sadness made her able to keep her daughter in her mind.

Table 1. The sample characteristics (the low-risk group)

Parent Gender	AAI Classification	Child Gender	CARE-Index Age of the child Parental sensitivity
P2 M	IO(R) Utr(dpl)EN Utr(p)EA Utr(p)PC	Nils M	36 months sensitivity: 7
P4 F	IO(R) Utr(p)DV	Annina F	31 months sensitivity: 7

Note. IO(R)=Insecure other, partial reorganization; Utr(dpl)EN=displaced trauma of emotional neglect; Utr(p)EA=preoccupied trauma of emotional abuse; Utr(p)PC=preoccupied trauma of parental conflicts; Utr(p)DV=preoccupied trauma of domestic violence.

Moderate-risk group

Two mothers had triangulated C5-6 strategies in the medium range, interrupted by unresolved traumas and losses. P3 displayed 'at risk' sensitivity and P5 on the border to 'inept' (see Table 2).

P3 and her son Robin

P3 was interviewed with the AAI and video filmed for the Infant CARE-Index with Robin, when he was 7 months old, and for the Toddler CARE-Index when Robin was 28 months old. P3 used a C5-6 strategy, interrupted by many unresolved traumas and early losses. She had a few reminiscences before the age of six years, the age at which her father died. The interaction of P3 with her son was in the risk range of the Infant CARE-Index. P3 imitated play by mechanically offering toys without highlighting them or taking any notice of what Robin was interested in. This intruded on what Robin was doing, and he did not attend much to the toys presented by his mother. P3 did not display an interest in Robin's intentional world. One time she teased with a toy, calling Robin to turn to and crawl to her accompanied by false positive affect: 'Come on!' When Robin approached her knees, and touched her long hair, she withdrew and Robin quickly turned away as if expecting the rejection. P3 was very uncomfortable with Robin's physical proximity-seeking, which may also reflect her preoccupied trauma in regard to the childhood sexual abuse that emerged in her AAI. Trauma-related stimuli including the child's distressed state may trigger high arousal in the mother, who momentarily had to protect (or defend) herself against the threatening arousal by turning away from the physical touch of her son. She had to protect herself, that is, her struggle for self-regulation temporarily competed with the resources for sensitive caregiving. Thus, her sensitivity to the signals of her child momentarily decreased as well as her ability to engage in mutual regulation of arousal and emotion with her son (Suardi et al. 2017). In the Toddler CARE-Index her sensitivity level was the same. Robin was in charge of the play that also involved buying and selling. When confronted with the frustration, Robin did not display any

negative affect. Instead, he showed social flexibility starting to exchange goods in order to get back what he wanted.

P5 and her daughter Augusta

P5, Augusta's mother used a C5-6 strategy, modified by unresolved traumas. Deep-seated feelings of worthlessness, connected to parental emotional and physical abuse, lurked behind her façade of restless talkativeness. Her greatest fears were connected to being confronted once again with the abusive, unfair and mortifying treatment that she had experienced with her childhood parents. She was still very angry, accusing, in particular, her father to single out her as the 'black sheep' and preferring her brother. In the Infant CARE-Index, P5 was predominantly controlling and her sensitivity was on the border to inept. P5 instructed her daughter, but was not affectively engaged and looked slightly bored. The rhythm was hectic. P5 initiated activities and Augusta vigilantly followed. P5 was aversive to her daughter's physical touch, maybe also reflecting her preoccupied trauma of childhood sexual abuse by a relative as told in the AAI.

Table 2. The sample characteristics (the moderate-risk group)

Parent Gender	AAI Classification	Child Gender	CARE-Index Age of the child Parental sensitivity
P3 F	C5-6Δ Ul(p,dpl)F Utr(p)SA by SF Utr(p,ds)PA by SF, BF	Robin M	7 months 28 months sensitivity: 4
P5 F	C5-6Δ Utr(p) EA,PA Utr(p,dpl)CSA by a relative	Augusta F	13 months sensitivity: 5

Note. C5-6Δ=Punitive-seductive, triangulated strategy; Ul(p,dpl)F=preoccupied and displaced loss of father; Utr(p)SA by SF=preoccupied trauma of sexual abuse by step-father; Utr(p,ds)PA by SF, BF= preoccupied and dismissed trauma of physical abuse by step-father and boyfriend; Utr(p)EA,PA=preoccupied trauma of emotional and physical abuse; Utr(p,dpl)CSA by a relative=preoccupied and displaced trauma of childhood sexual abuse by a relative.

High-risk group

Two mothers displayed sensitivity and utilized self-protective strategies in the high risk range, for one of the mothers, broken by the modifier disorientation (DO) and for both interrupted by several unresolved traumas (see Table 3).

P1 and her son Henry

P1, Henry`s mother had a disoriented blended A3 C3 strategy. She portrayed in the AAI the image of a highly triangulated family with two schismatic parents, most of the time fighting and derogating each other, and herself balancing between them as the care-giving go-between. Both parents, her temperamental mother and alcohol-abusing father, physically and emotionally abused their children, the full impact of which she denied. For P1, the result was disorientation and high arousal. In CARE-Index terms, she was classified as Unresponsive a (cheerfully chattering and acting without any initiation by her child) (Crittenden 2010) and her sensitivity was in the high-risk range. She talked and did a lot, but her doings were not connected to the signals of Henry. The aim of her speech was not only to act according to an internal script of a good mother, but also to act out her own free-floating intense anxiety she could not contain (Ikonen and Rechardt 1980). The semantics, i.e. the meaning of her speak, did not matter and she was not able to reflect what she said. P1 could not stop chattering independent of if Henry smiled, whimpered or tried to handle toys. As her unpredictable and elusive behavior was not contingent on Henry's behavior, she was a blurry target for him and Henry was confused.

P6 and her daughter Ewa

P6, Ewa`s mother had an extreme A7 strategy. She had learned strongly to inhibit affect because of lack of early affective attunement and comfort, and because of fear of her father's anger, both toward her and her mother in the discordant spousal relationship. In the AAI, she claimed she was to blame for problems in her parents' relationship. Because of the strong denial of her desire for comfort, her fear, and, in particular, her anger, she had great problems in accessing negative affect. She acted out her own feelings of being bad and deviant in her adolescent years through risk-taking oppositional behavior, also escalating drug abuse, and she was taken into custody for some years.

In Toddler CARE-Index, P6 sat at a distance, hands between her legs. In the CARE-Index terms, she was classified as mostly Unresponsive b (blatant form of unresponsive), at the same time tried to look and to speak like a 'good' mother, but with an odd metallic-monotonous voice and false positive affect, resulting in some Unresponsive a points (Crittenden 2005). Ewa was on the floor, aroused, wiggly, talking with a cheerful voice, playful, seemingly self-reliant, as if not needing anybody to play with her. However, Ewa retreated obliquely to her mother, awkwardly squirmed in her mother's lap. P6 made no anticipatory moves and did not fully accept Ewa's body in her lap, displaying a slight grimace. They sat back of child to torso of mother, no face-to-face contact. P6's hands were pinned under her legs resulting in awkward holding of Ewa. When P6 took away the camera during the frustration task, Ewa fought to keep it, then gave up and showed a pouty face that her mother could not see. When Ewa got the camera back, she was not satisfied. She clapped the roof of the doll-house, hit her mother's knee in an ambiguous way, as if both accidentally and on purpose, and P6 moved out of range with an affectless face and hands kept tucked away. Ewa hit her mother in the same way as she entered her lap, as if not intentional. There was a great lack of affective reciprocity. P6 tried to present an elegant, but artificial façade. However, the coders felt the 'emptiness' in the total lack of affective attunement to her daughter. Ewa tried both to act in a self-reliant way and to elicit the attention from her distant, still and physically aversive mother, by using both feigned helpless and threatening behaviors. Ewa was in the lead, the mother responding as minimally as possible. P6 was physically aversive to her daughter functioning as a resistant 'sofa', like an in-animate object. She did not respond to Ewa, when her daughter lightly hit her. She only moved further away.

Table 3. The sample characteristics (the high-risk group)

Parent Gender	AAI Classification	Child Gender	CARE-Index Age of the child Parental sensitivity
P1 F	DO A3 C3 Utr(p,ds)PA,EA Utr(dn)EN Utr(p)DV	Henry M	17 months 21 months 40 months sensitivity: 2
P6 F	A7 Utr(dn)EN Utr(dn)paternal anger Utr(dn)taken into custody	Ewa F	32 months sensitivity: 2

Note. DO A3 C3= blended compulsive caregiving and coercive aggressiveness, modified by disorientation; Utr(p,ds)PA,EA=preoccupied and dismissed trauma of physical and emotional abuse; Utr(dn)EN=denied trauma of emotional neglect; Utr(p)DV=preoccupied trauma of domestic violence; A7=delusional idealization; Utr(dn)paternal anger=denied trauma of paternal anger; Utr(dn)taken into custody=denied trauma of being taken into custody.

Discussion

Because of the small sample size, the study is more exploratory than confirmatory. The results should be generalized with caution. The present study showed a great variation of self-protective strategies of parents with ADHD including the degree of risk in the dyadic interaction between the parent and their children. Three subgroups of parents were formed on the basis of risk as indicated by Crittenden's (2016) gradient of transformation of information. The more complex the parent's self-protective strategy was, and the more it was modified by disorientation, the less sensitive was the interaction, that is, some parents' need for self-protection compromised their ability to protect their child and decreased their sensitivity to their child. Thus, this study using the more subtle DMM assessment methods indicated the necessity of further research regarding the intra-group variety of the protective strategies and sensitivity of parents with the exclusive ADHD diagnosis. Additionally, all parents displayed indications of unresolved traumas in their AAI discourse that momentarily could interrupt their strategic functioning in inexplicable ways, decrease their sensitivity to the their children and their ability to engage in regulation of emotion with them as assessed by the CARE-Index. Ringer and Crittenden (2007) and Dallos and Smart (2010) stress the disrupting effects of the parents' unresolved traumas on their children, if their unresolved experiences of danger and distress are triggered in interaction with their children. As Svanberg, Mennet, and Spieker (2010, 375) point out, 'in view of the notion that early relationships have an impact not only on how infants construct their minds, but also how they build their brains, interventions that alleviate early risk are useful'. This indicated the importance of also working with parental traumas.

Because the sensitivity of these parents differed, their needs of treatment also varied. All parents had got medication and some of the parents had received outpatient counselling, but

none had received individual psychotherapy. The DMM assessment methods offer new opportunities for intervention planning, how to respond to family distress to protect endangered children (see Spieker and Crittenden 2018). These parents would benefit from an attachment oriented family psychological assessment, assessments of the self-protective strategies of both parents and children and a treatment tailored to the unique family needs (Crittenden et al. 2014). In particular, mothers of the moderate and high-risk groups would need a more intense intervention (see levels of intervention, Svanberg, Mennet, and Spieker 2010), but also the low risk group would need help in working through their unresolved traumas.

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Notes on contributors

Milla Syrjänen is a PhD student at the Faculty of Educational Sciences, University of Helsinki.

Airi Hautamäki, PhD, is a professor emerita in social psychology and psychology at the Swedish School of Social Science, University of Helsinki.

Natalia Pleshkova, PhD, is an associate professor at the Division of Child and Parent Mental Health and Early Intervention, St.Petersburg State University.

Sinikka Maliniemi, MA, is a psychologist and a psychoanalytic psychotherapist in private practice. She is also a consultant in regard to early family intervention.